DEPARTMENT OF SOCIALSERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 605-773-3495
FAX: 605-773-5246
EMAIL: Medical@state.sd.us
WEBSITE: dss.sd.gov

Dear South Dakota Medical Assistance Provider:

Attached please find an authorization agreement that will allow for the direct deposit of your South Dakota Medical Assistance payments. Direct deposit allows your payments to be electronically deposited into your bank account. Direct deposit is a faster and safer way to get your money into your account without having the worry of lost, stolen, or damaged warrants. With direct deposit, your money will be in your account within one or two business days after our payroll runs.

The enclosed authorization simply gives the Division of Medical Services and our financial institution authority to deposit your Medical Assistance payments to the bank account you specify. There is no cost to Medical Assistance providers for this service.

The Division of Medical Services will continue to mail your paper remittance advices documenting your claim adjudication activity. However, direct deposit capabilities lay the foundation for electronic delivery of remittance advices in the future.

I strongly encourage all Medical Assistance providers to take advantage of direct deposit capabilities. Direct deposit opens the door for both providers and the Medical Assistance program to expand their automation capabilities.

If you have any questions regarding this matter, please call our office at 1-800-452-7691

Sincerely,

Larry Iversen
Division Director
Division of Medical Services

Return to Provider Enrollment

South Dakota Medical Assistance Authorization Agreement For Direct Deposit of Payment

I hereby authorize the Department of Social Services, Division of Medical Services to initiate direct deposit of my payment into the depository which I have indicated below, and to initiate any debit or credit entries to my account which may be needed to correct any errors that have occurred.

Provider Name: _____

Medical Assistance Provider Number: _____

Financial Institute: _____

Branch: _____

City: _____ State: _____ Zip: _____

Transit ABA No: _____

Account No: _____

Type of Account (Checking or Savings) _____

PLEASE ATTACH A VOIDED CHECK TO ASSURE ACCURATE ACCOUNT INFORMATION.

This agreement is to remain in full force and effect until the Division of Medical Services has received written notification from me of its termination in such time and in such manner as to afford the Division of Medical Services and the depository a reasonable time to act.

Authorized Signature: _____ Date: _____

Contact Person: _____ Telephone #: _____

Please return this form to:

Provider Enrollment
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291